MONTANA
Department of Public Health & Human Services

March 7, 2008

Montana Healthcare Programs Notice

Outpatient Hospital, Emergency Room, Podiatry, Physician, Mid-Level Practitioner, IDTF, Free-Standing Dialysis Clinic, Birthing Center, Laboratory and X-Ray, Pharmacy, Public Health Clinic, Psychiatry, Ambulatory Surgery Center (excludes Inpatient Hospital, FQHC, RHC, DME, Ambulance, Indian Health Service, Dentist, and all others not mentioned above)

Billing Procedures Regarding National Drug Code (NDC)

Background Information

The Federal Deficit Reduction Act of 2005 mandates that all State Medicaid Programs require the submission of National Drug Codes (NDCs) on claims submitted with certain procedure codes for physician-administered drugs. This mandate affects all providers who submit claims for procedure-coded drugs both electronically and manually.

Effective April 1, 2008, Montana Medicaid will require all claims submitted for physician-administered drugs to include the NDC(s), the corresponding CPT/HCPCS code, and the units administered for each code. Montana Medicaid will reimburse only on drugs manufactured by companies that have a signed rebate agreement with CMS. A list of drug manufacturers who have a rebate agreement can be found at:

http://www.cms.hhs.gov/MedicaidDrugRebateProgram/10_DrugComContactInfo.asp

This list is updated every April.

Remittance Advice

Remittance advices (RAs) will not display the NDC submitted on the claim. Providers are encouraged to contact Electronic Data Interchange (EDI) toll-free at 800-987-6719, or on the web at MTEDIHelpdesk@ACS-inc.com to obtain additional information about denied claims.

NDC Requirements

General

Effective April 1, 2008, Montana Medicaid will require all claims submitted for physician-administered drugs to include the NDC(s), the corresponding CPT/HCPCS code, and the units administered for each code.

Formatting
The NDC is an 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. This 11-digit code is composed of a 5-4-2 grouping. The first grouping of five digits is the labeler code as assigned to the manufacturer by the Federal Drug Administration. The second grouping of four digits is assigned by the manufacturer and describes the ingredients, form of the dosage, and strength of the dosage. The last grouping of two digits describes the packaging size.

1 2 3 4 5	**6 7 8 9**	10 11
Labeler Code	Manufacturer's code	Packaging Size

The NDC **must** be recorded (no spaces, no punctuation) as an 11-digit series of numbers in order to be valid. **Claims will be denied for drugs billed without a valid 11-digit NDC.**

It is possible that the labeler may have omitted any leading zeros in the NDC for a particular pharmaceutical which would result in an invalid NDC containing less than 11 digits. To ensure proper payment of the claim, the provider must add the appropriate number of leading zeros to the beginning of the affected segments. By doing so, the NDC will be reported as a valid 11-digit code following the 5-4-2 format.

Quantity
The procedure code billing units and NDC quantity may not always be the same amounts. The NDC quantity is based upon the strength of the drug administered per unit and the designated strength of the procedure code. The NDC quantity billed must reflect the procedure code quantity billed on the claim.

Reporting NDC on the Electronic 837P or 837I

Filing claims electronically is the preferred method of claim filing as it allows for the fewest amount of errors and expedites claim processing and payment. Providers may create electronic claims using the 837 format and send these claims directly to ACS EDI Gateway Inc. at no charge to the provider. The software to facilitate electronic filing (WINSAP 2003, version 5.13) is also provided at no charge. Providers must be enrolled as a Montana Medicaid Provider and must also enroll with ACS EDI Gateway.

The NDC is reported in Loop 2410, Segment LIN, Data Element 03 of the 837. You may report up to 25 NDCs for each CPT/HCPCS line code.

The following information must be reported on the 837:

- National Drug Code – Enter the valid 11-digit code following the 5-4-2 format (the N4 qualifier is not applicable for electronic filing).
- Drug Unit Price – Enter the unit price. This is a required field.
- Unit of Measurement – Enter the unit of measurement. This is a required field.

- F2 – International Unit
- GR – Gram
- ML – Milliliter
- UN – Units

Examples of how unit of measure qualifiers relate to NDC dose/volume:

NDC Dose/Volume	Unit Qualifier
1,000ml	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

- Quantity – Enter the quantity. This is a required field.
- Prescription Number – If available, is not required.

Some revenue codes require a procedure code for all outpatient hospital services and the units administered for each code. CPT/HCPCS codes billed under those revenue codes that are for physician-administered drugs must include the NDC(s).

Reporting NDC on the Paper CMS-1500

The following is a list of potential procedure codes that may apply to physician administered drugs:

A4216-A4218	A9500-A9699	P9041-P9050	Q3025-Q3026
A4706-A4728	C1716-C1720	Q0112	Q4079-Q4081
A4760-A4766	C2633-C2637	Q0163-Q0181	Q4083-Q4095
A4802	C9003-C9399	Q0515	Q9945-Q9964
A6250	J0120-J9999	Q2004-Q3001	

To report the NDC on the CMS-1500, under Form Locator 24, enter the valid 11-digit NDC in the shaded area on the left side of the form within each procedure line:

- Enter the NDC qualifier of “N4” in the first two positions of the NDC.
- Enter the valid 11-digit NDC following the qualifier (N4).
- Follow the 5-4-2 format when entering the NDC.
- Enter the NDC unit of measure qualifier:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Units

Examples of how unit of measure qualifiers relate to NDC dose/volume:

NDC Dose/Volume	Unit Qualifier
1,000ml	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

- Enter the NDC quantity (the administered amount) to the nearest whole number. For actual units that are less than one (1), please bill these units using the whole number of one (1). Examples would be:

Actual Amount	Billed Amount
.11ml	1.0ml
.95g	1.0mg
26.5mg	27.0mg

The N4 qualifier, 11-digit NDC, unit of measure, and quantity are entered without hyphens, commas, decimal points, or spaces.

Billing Requirements

The paper CMS-1500 will accept one NDC for each of its six lines of coding. Claims will be denied without a valid 11-digit NDC that follows the 5-4-2 format. If the line has more than one NDC associated with it and the provider is billing on paper, each ingredient should be billed on a separate line with the appropriate CPT/HCPCS code and the corresponding NDC data. The following modifiers will be used to denote the components:

KO – single drug unit dose form
KP – first drug of multiple drugs
KQ – second or subsequent drug of multiple drugs

Reimbursement Policy

Payment to the provider for physician-administered drugs is currently made using the reimbursement methodology for provider type based on the billed CPT/HCPCS code. These reimbursement methodologies will not change.

Professional providers using the CMS-1500 that bill compound drugs must bill this charge using CPT/HCPCS code J3490 on paper claim forms and must attach an invoice. Payment will be made from the NDCs listed on the invoice that qualify for rebates. These claims and invoices must be mailed to:

Medicaid Physician Services
P.O. Box 202951
Helena, MT 59620-2951

Crossover Claims
Dual-eligible claims billed to Medicare with an NDC will cross to Medicaid with the NDC. Any physician-administered injectable crossing to Medicaid from Medicare without an NDC will be denied. Claims denied for this reason may be re-billed with the proper NDC within one year of the date of service.

An example of a paper CMS-1500 is attached (Attachment A).

Reporting NDC on the Paper UB-04

To report the NDC on the UB-04, enter the following information into Form Locator 43 in the Revenue Description Field:

- Enter the NDC qualifier of "N4" in the first two positions on the left side of the field.
- Enter the 11-digit NDC numeric code in the 5-4-2 format.
- Enter the NDC unit of measure qualifier:
  - F2 – International Unit
  - GR – Gram
  - ML – Milliliter
  - UN – Units

  Examples of how unit of measure qualifiers relate to NDC dose/volume:

NDC Dose/Volume	Unit Qualifier
1,000ml	ML
50,000IU	F2
1Unit	UN
50mg	GR
100mg/4ml	ML

- Enter the NDC quantity (the administered amount) to the nearest whole number.

The information on the Revenue Description Field is entered without delimiters such as hyphens or commas, and any unused spaces for the entire quantity are left blank. The Description Field allows for a maximum of 24 total characters.

Billing Requirements
Some revenue codes require a procedure code for all outpatient hospital services and the units administered for each code. CPT/HCPCS codes billed under those revenue codes which are for physician-administered drugs must include the NDC(s). The following is a list of potential procedure codes and revenue centers that may apply to physician-administered drugs:

Procedure Codes	Revenue Codes**
A4216-A4218	272
A4706-A4728	822, 832, 842, 852
A4760-A4766	822, 832, 842, 852
A4802	822, 832, 842, 852
A6250	272, 623
A9500-A9699	343, 344, 636,
C1716-C1720	272, 278
C2633-C2637	272, 278
C9003-C9399	278, 636
J0120-J9999	250, 636
P9041-P9050	386, 390, 399, 636
Q0112	300, 306
Q0163-Q0181	250, 636
Q0515	636
Q2004-Q3001	250, 278, 636
Q3025-Q3026	250, 636
Q4079-Q4081	636
Q4083-Q4095	636
Q9945-Q9964	254, 255, 636, 96X, 97X, 98X

**Check recent Uniform Billing Editor for appropriate revenue centers for each code

Providers that bill compound drugs on the UB-04 paper claim form must bill each specific drug in the compound on separate lines using the appropriate CTP/HCPCS code for each drug. In addition, the appropriate NDC and utilization information must be reported. If the line has more than one NDC associated with it and the provider is billing on paper, each ingredient should be billed on a separate line with the appropriate CPT/HCPCS code and the corresponding NDC data. The following modifiers will be used to denote the components:

KO – single drug unit dose form
KP – first drug of multiple drugs
KQ – second or subsequent drug of multiple drugs

Reimbursement Policy
Payment to the provider for physician-administered drugs is currently made using the reimbursement methodology for facility type (OPPS or CAH) based on the billed HCPCS code. These reimbursement methodologies will not change.

The department will deny claim lines with dates of service on or after April 1, 2008, that do not report an NDC and/or are not manufactured by companies that have a signed rebate agreement with CMS.

For claims in which a line denied because no NDC was included, providers will have 365 days from the date of service to resubmit or adjust a claim to receive payment.

An example of a paper UB-04 is attached (Attachment B).

Contact Information

Should providers have questions about the information included in this bulletin, please feel free to contact the following resources:

Provider Relations toll-free in- and out-of-state: 1-800-624-3958
Helena: (406) 442-1837
Fax: (406) 442-4402
Written inquiries addressed to:
Provider Relations
Box 4936
Helena, MT 59604

EDI Technical Help Desk toll-free in- and out-of-state: 1-800-987-6719
Helena: (406) 442-1837
Fax: (406) 442-4402
Written inquiries addressed to:
ACS
Attn: MT EDI
Box 4936
Helena, MT 59604

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

Medicaid Only Coverage

Fill Colors:
- Required Fields
- Conditional Fields
- Other

Boarder Colors
- Client Fields
- Provider Fields
- Billing Fields

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) [X] | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Flintstone, Fred T

3. PATIENT'S BIRTH DATE: 08 30 60 | SEX: M [X] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 112 Rocky Rd.

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY: Bedrock | STATE: BC

8. PATIENT STATUS: Single Married [X] Other | Employed [X] Full-Time Student Part-Time Student

CITY | STATE

ZIP CODE: 54321-1234 | TELEPHONE (Include Area Code): (406) 765-4321

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [X] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES [X] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [X] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME: Medicaid

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 123456789

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO — *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP): 01 01 07

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Great Gazoo MD

17a. 1D 9954321

17b. NPI 1234567890

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO | $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. L 780 . 60

2. _____

3. _____

4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	N4 55513001404 UN200									ZZ	36LP000X
	01 01 07	01 01 07	11	0	J0881		1	5 99	1	Y	NPI 1213456789
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER: 99-9999999 | SSN | EIN [X]

26. PATIENT'S ACCOUNT NO.: 123456789

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Rocky Shalestone, MD | 01/01/07

SIGNED | DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI | b.

33. BILLING PROVIDER INFO & PH #: (406) 555-1234

Yabba-Dabba Center
2121 Granite Slab Dr.
Bedrock, BC 54321-1234

a. 9876543210 | b. ZZ 400RT001X

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

Medicaid Only

Required Fields are Highlighted

1 Take Time Medical Center 104 Time Square Helena, MT 59601-0104	2	3a PAT. CNTL #: 4806 b. MED. REC. #: Grisw97531 5 FED. TAX NO.	4 TYPE OF BILL: 131 6 STATEMENT COVERS PERIOD FROM: 02/01/07 THROUGH: 02/04/07 7: 9912345

8 PATIENT NAME a: Pat.'s ID b: Griswold, Clark	9 PATIENT ADDRESS a: 1313 Mockingbird Lane, Metropolis, MT 59601-1313 b c d e	10 BIRTHDATE 03/26/30	11 SEX M	12 ADMISSION DATE 02/01/07	13 HR 11	14 TYPE 1	15 SRC	16 DHR	17 STAT 01

18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES | 29 ACDT STATE | 30

	31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37
a							a
b							b

38
Griswold, Clark
1313 Mockingbird Lane
Metropolis, MT 59601-1313

	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a			
b			
c			
d			

	42 REV. CD.	43 DESCRIPTION (NDC)	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	120	Room and Board			4	3200 00		1
2	259	Other Pharmacy N4 00026064871 GR 150			1	620 00		2
3	270	General Class Medical/Surgical Supplies			110	583 00		3
4	300	General Class Laboratory			4	500 00		4
5–22								5–22
23	PAGE ____ OF ____		CREATION DATE 04/01/07		TOTALS	333 60		23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI: 1876543210
A	Medicaid						57
B							OTHER PRV ID
C							

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Griswold, Clark		123456789		
B					
C					

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
10987645321		

66 DX: 780.39

A B C D E F G H 68
I J K L M N O P Q

69 ADMIT DX	70 PATIENT REASON DX a b c	71 PPS CODE	72 ECI a b c	73
540.0				

74 PRINCIPAL PROCEDURE CODE / DATE	a. OTHER PROCEDURE CODE / DATE	b. OTHER PROCEDURE CODE / DATE	75
c. OTHER PROCEDURE CODE / DATE	d. OTHER PROCEDURE CODE / DATE	e. OTHER PROCEDURE CODE / DATE	

76 ATTENDING	NPI	QUAL	
LAST: Munster	FIRST: Herman	NPI: 1766554433	QUAL: ZZ 363PL000X
77 OPERATING	NPI	QUAL	
LAST: Adams	FIRST: John	NPI: 0123456789	QUAL: zz 363LP000X
78 OTHER	NPI	QUAL	
LAST	FIRST		
79 OTHER	NPI	QUAL	
LAST	FIRST		

80 REMARKS

81 CC	
a	363LP0222X
b	
c	
d	

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

NUBC National Uniform Billing Committee LIC9213257

Fill Colors (shaded areas are slightly darker):
- Required Fields
- Conditional Fields
- Other

Boarder Colors
- Client Fields
- Provider Fields
- Billing Fields